2011 WL 7266942 (Mich.Cir.Ct.) (Trial Motion, Memorandum and Affidavit)
Circuit Court of Michigan.
Wayne County

Sharon JONES as Personal Representative of the Estate of Ronald Jones, deceased, Plaintiff,

v.

KINDRED HOSPITAL - Detroit an Assumed name for Kindred Hospitals East, LLC a Foreign Limited Liability Company, Jawad Thamer, M.D., Jointly and Severally, Defendants.

No. 09025626NH.
September 30, 2011.

Plaintiff's Brief in Response to Defendant, Jawad Thamer, M.D.'s Motion for Summary Disposition or for An Evidentiary Hearing

Kenneth T. Watkins (P46231), Sommers Schwartz, P.C., Attorneys for Plaintiff, 2000 Town Center, Suite 900, Southfield, Michigan 48075-1100, (248) 355-0300.

Renee S. Siegan (P22953), Saurbier & Siegan, P.C., Attorneys for Def. Thamer, 400 Maple Park Boulevard, St. Clair Shore, MI 48081, (586) 447-3700.

Nicole K. Nugent (P60218), Sullivan, Ward, Asher & Patton, Attorney for Def.hospital, 25800 Northwestern Highway, Suite 100, Southfield, MI 48075-8412, (248) 746-0700.

Hon. Jeanne Stempien.

This wrongful death medical malpractice case arises from the death of a 44-year old Ronald Jones from an apparent narcotic-induced respiratory arrest. Defendant, Jawad Thamer, M.D., the physician managing Mr. Jones' medical care at Defendant Kindred Hospital as of February 22, 2007, and the physician who ordered placement of a 75 mcg Fentanyl (a/k/a Duragesic) patch upon Mr. Jones that day, has brought a motion for summary disposition asserting that the deposition testimony of Plaintiffs expert, Paul Genecin, M.D., fails to support Plaintiffs allegations that Defendant Dr. Thamer breached the standard of care by allowing decedent to become overdosed with narcotic medications, or the allegation that respiratory arrest was the cause of decedent's death. Alternatively, Defendant asks this honorable Court to hold an evidentiary hearing to determine the scientific reliability of Dr. Genecin's opinions. For the reasons presented below, Plaintiff asks that Defendant's motion be denied.

I. STANDARD OF REVIEW

Defendant brings his motion for summary disposition pursuant to MCR 2.116(C)(10).

A motion under MCR 2.116(C)(10) must show that, except for the amount of damages there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Such a motion tests the factual sufficiency of a claim. Wilson v. Alpena Co Rd Comm, 474 Mich 161, 166 (2006). The court is permitted to consider affidavits, pleadings, depositions or other documentary evidence, but the court may not itself make findings of fact nor weigh credibility in deciding the motion. Skinner v. Square D Co, 445 Mich 153, 161 (1994). The court must give the benefit of all reasonable doubt to the party opposing the motion. White v. Taylor Distributing Co, 482 Mich 136, 139 (2008). In cases involving questions of intent, credibility, or state of mind, summary disposition is rarely appropriate. Michigan National Bank v. Wheeling, 165 Mich App 738 (1988), In re Handelsman, 299 Mich App 433, 438-439 (2005).

The court should be liberal in finding a question of material fact. *Lash v. Allstate Ins Co*, 210 Mich App 98, 101 (1995). The evidence presented and all reasonable inferences therefrom must be viewed in a light most favorable to the opposing party. *Reed v. Breton*, 475 Mich 531, 537 (2006).

II. FACTUAL BACKGROUND

In August 2006, Ronald Jones underwent a triple coronary artery bypass procedure with saphenous vein graft harvested from his left leg. His post-operative course was complicated by pulmonary issues and vascular insufficiency in his lower extremities. As catalogued in Defendant's brief, Mr. Jones suffered multiple co-morbidities over the course of the following years - including, as relevant here, chronic obstructive pulmonary disease (COPD), pulmonary disease, obstructive sleep apnea, severe peripheral vascular disease, congestive heart failure, coronary artery disease - which required an ongoing submission to medical treatment, surgeries, and rehabilitative care. He was often in pain, and frequently prescribed various medications, including narcotic medications, to help alleviate his pain.

The events immediately preceding decedent's death start at Henry Ford Hospital-Wyandotte, in January 2007, where Mr. Jones presented with a chronic nonhealing wound in his left foot and occlusive disease in his right foot. He underwent a debridement procedure for the wound and revascularization surgery. During this hospital stay, which continued until February 20, 2007, Mr. Jones was administered several pain reliever medications, including Ultram, Tylenol, Dilaudid, and Fentanyl (Duragesic). Of particular significance was the placement of a 50 mcg Fentanyl patch at this facility at 10:00 p.m. on February 18, 2007.

Briefly, a Fentanyl or Duragesic patch is a method of delivering an analgesic narcotic continuously through the skin. It is used to help control a patient's pain. The medication delivered through this method enters the system more slowly than an IV or oral medication, reaching its peak levels many around 17 hours after it is applied. It is designed for long-term continuous pain relief. Accordingly, the patient, while benefiting from the relief afforded by this medication might nevertheless from time to time experience more acute episodes of pain - breakthrough pain - requiring the administration of an additional fast-acting pain relieving medication to subdue that breakthrough pain.

The standard of practice is to remove and replace a new Fentanyl patch every 72 hours as the patch will have dispensed most or all of its medication into the patient's system by then and lose its effectiveness. The standard of practice also calls for the documentation of the patch as removal showing that it has been properly disposed of in accordance with the protocols for deposing narcotic medications. This is mentioned here because in the present case the medical records are silent as to when (or even if) this Fentanyl patch placed on decedent on February 18 was removed. This case concerns the placement of a subsequent 75 mcg Fentanyl patch on decedent at 10:50 a.m. on February 22, 2007. (Defendant Dr. Thamer ordered the patch at 9:50 a.m. but the patch was not placed until an hour later.) If the standard of practice had been followed, then the 50 mcg patch placed on decedent would have been removed at 10:00 p.m. the previous night, the 21st, thereby leaving a gap of nearly 13 hours in which decedent's system would have been free of Fentanyl before the new patch was placed (which would have the effect of reducing the level of narcotic tolerance). However, there is simply no record of what happened to this earlier placed patch.

What is documented is that on February 20, 2007 Ronald Jones was transferred from Henry Ford Hospital-Wyandotte to Kindred Hospital. While at Henry Ford Hospital, Mr. Jones, besides being given the Fentanyl patch had also been given 1 mg of IV Dilaudid every 3 hours for his pain. [1] Upon admission to Kindred Hospital, an order was written by Dr. Lavine directing that Mr. Jones receive 2 mg of IV Dilaudid every_4 hours. Mr Jones' medical records affirm-that this pain relieving narcotic was regularly administered to Mr. Jones in the course of the next two days.

At this point it is appropriate to pause to address something that Plaintiffs expert, Dr. Genecin, attempted to explain in his deposition. Defendant's present motion is largely premised on the assertion that the medical literature can be read as suggesting that there is nothing improper in giving Dilaudid to a patient who is on a Fentanyl patch to treat the patient's breakthrough pain. Whether or not that is correct is not especially relevant here. Here the administration of the Dilaudid was not prescribed for

breakthrough pain but rather appears to be an attempt to provide long-term pain management as standing order. The Dilaudid was not being given as needed, but at regular 4-hour intervals. The malpractice occurred when Dr. Thamer came along and then ordered a 75 mcg Fentanyl patch to be superimposed upon this standing order for Dilaudid. (Genecin dep, 58, 67) (Exhibit 1)

As Dr. Genecin affirmed, his first contention against Defendant is that Dr. Thamer breached the standard of practice in ordering the 75 mcg Fentanyl patch in addition to the standing dose of IV Dilaudid. When asked to explain why he felt this way a breach of the standard of care he first noted that the order for Dilaudid was "treated as a standing dose" by Dr. Thamer "so that while his Fentanyl patch is causing the level of Fentanyl in his blood to go up, he's also getting a potent IV narcotic in the form of Dilaudid and these drugs potentiate each other." Dr. Genecin also noted that the patient was receiving another drug, Restoril (a hypnotic sedative) and had underlying chronic obstructive lung disease and sleep apnea that were also factors making him a **vulnerable** patient. (Id, 58) [2]

Thus, notwithstanding the fact that Ronald Jones had a history of COPD and sleep apnea (not to mention the rest of his adverse medical history) and was already receiving 2 mg IV Dilaudid every 4 hours and other suppressive medications, at 9:50 a.m. on February 22, 2007, Defendant Dr. Thamer ordered a 75 mcg Fentanyl patch for Mr. Jones, that was placed an hour later. The combination of the 75 mcg patch and the IV Dilaudid eventually produced changes suggestive of over-sedation. At around 8:00 p.m., 9 hours after the Fentanyl patch was placed, the hospital progress notes indicate Mr. Jones having "slurred speech" and 'dozing off' although he still was alert enough to converse and request more pain medication. At 1:30 a.m. on the 23rd he was observed by the nurse to be "slightly lethargic" but still alert and oriented. He was given his last dose of Dilaudid at around this time. An hour later the nurse noted that Mr. Jones was sleeping, but easily aroused. This is the last progress note until 7:18 a.m. when Mr. Jones was found unresponsive with a respiratory rate of 4 (breaths a minute) and a heart rate of 44. This was now about 18 hours and 20 minutes after the patch was placed.

Defendants have made the suggestion that this discovered respiratory arrest could not have been due to the Dilaudid given at 1:30 a.m. as it was close to 6 hours afterwards that Mr. Jones was found in this state and the effects of Dilaudid only last 4 hours. But this is not correct. The half-life of Dilaudid, Dr. Genecin testified, is 4 to 6 hours (Id, 31, 94) and would have still been in Mr. Jones system. Importantly,Mr. Jones was-not being monitored, was not on any machines that can tell us when, after the nurse last saw him at 2:30, he suffered the crisis that precipitated the condition he was in when found at 7:18 a.m. Further, it was not the Dilaudid per se that triggered this arrest, but also the rise of the amount of Fentanyl in his system:
But remember that it isn't just the Dilaudid; it's also the Fentanyl and the Fentanyl is on the upslope so you need to pass the threshold right of safety for the patient to stop breathing, and he may not have been there at two in the morning but he was certainly there at six in the morning.

(Id, 93)

Q. Is it your opinion that if the 1:30 dose of Dilaudid had not been given, Mr. Jones would not have arrested.

A. I think that's more likely than not.

Q. In your opinion, it was the last dose of Dilaudid that was the issue?

A. Any time that the Dilaudid was stopped after the Duragesic was started, that would have reduced the risk of harm to the patient. Each successive dose posed a risk of harm from respiratory depression, and the one that was most recent is going to be the one that's going to be contributing most of the Dilaudid that's in the system.

...I think the issue is that it's a potent high dose narcotic being given by vein in a patient whose level of Fentanyl is rising quickly, that's the issue. And each dose increases the risk of harm, but the most recent dose is the one that the one that - both drugs contributed to the - actually, all three, Restoril, Fentanyl and Dilaudid all contributed to this patient's respiratory depression plus underlying disease, but those three medicines. The one that's new and different is the Fentanyl. It's either new because he

wasn't going to have it for some time or it's just an increased dose. In any case, the level of that rising meanwhile, he's getting his regular dose of 2 milligrams of Dilaudid which is a lot of Dilaudid to be given to somebody IV It's going to be the last dose that would have been best to have been withheld because the point at which he reaches the threshold from Fentanyl, it's the interplay with the Dilaudid that's in his system so if he stopped Dilaudid sooner, it would have been better for him.

(Id, 94-95)

The Dilaudid would still have been in Mr. Jones' system when he arrested, and even if its level was not rising, that of the Fentanyl was. (Id, 96). Thus, according to Plaintiffs expert, it was this combination of drugs that more probably than not caused Mr. Jones to suffer a respiratory arrest.

That arrest, in turn, caused irreversible brain injury to Mr. Jones. He remained unresponsive and his family made the decision to take him off life-support. Mr. Jones died on March 8, 2007. A private autopsy was performed by Dr. Spitz, but was inconclusive as to pinpointing the cause of death. However, Plaintiffs expert gave in his deposition a detailed explanation as to why other potential causes of Mr. Jones' sudden death could be ruled out. (Id, 71-73) and affirmed that “more likely than not” Mr. Jones “had a narcotic analgesic overdose.” (Id, 73)

III. LAW AND ARGUMENT

Defendant's motion is asking this honorable gle Court to perform its “gatekeeper” role in exclusively evaluating the scientific *reliability* of the expert testimony proffered by Plaintiff in support of Plaintiffs medical malpractice claim. Plaintiff submits that the scientific reliability of the testimony of Plaintiffs expert is well established in this case, and the criticisms Defendant has presented in this motion go rather to the weight of the expert's opinions, not to their admissibility.

A. The Court's Limited Gatekeeper Role

In considering motions asking the court to perform its “gatekeeper” role with respect to expert testimony and pursuant to the standards that have been set forth in cases such as *Daubert v. Merrill Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed 2d 469 (1993), *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 119 S.Ct. 1167, 143 L.Ed 2d 38 (1999), *Craig v. Oakwood Hospital*, 471 Mich 67 (2004) and *Gilbert v. Daimler Chrysler Corp.*, 470 Mich 749 (2004), it is important that the trial court understand the limits of its inquiry. Both federal and state decisions caution that while the trial court must make a “searching inquiry” as to whether the proffered testimony satisfies the standards of reliability set forth in the rules of evidence - FRE 702 or MCL 702 - or by statute - *see*, MCL 600.2955 - the court's role extends no further than examining whether there is a scientifically reliable basis for the expert's opinion, and not to determining whether or not the conclusions drawn by the expert are true or credible. That decision remains a matter for the jury to resolve.

The inquiry to be undertaken by the trial court is a flexible one focusing on the principles of methodology employed and not on the conclusions reached. *Daubert supra.* The mere fact that two experts hold different opinions or come to diverse conclusions interpreting the facts of a case is not a basis for concluding that one or the other is scientifically flawed. As long as the expert's opinion rests upon a reliable or well recognized scientific foundation, the court should admit the testimony. (Id.)

An expert's conclusion is admissible if there are grounds for that conclusion, even if there may be some flaws to the expert's methods or there are arguable grounds for some alternative conclusion. (Id.) *See also, In re: Paoli Railroad Yard PCB Litigation*, 35 F 3d 717 (CA 3 1994). The evidentiary standard of reliability is lower than the standard of correctness. A court should find an expert's opinion reliable if it is based on good grounds, i.e., upon the methods and procedures of science. *Paoli, supra.* The grounds merely have to be good, not perfect, and the court should exclude opinion evidence only when it is seriously flawed. An opinion founded upon the facts, known scientific principles, professional experience, and the application of logic, is one

that rests upon a reliable methodology and should be admitted into evidence. All other criticisms merely go to the weight, not to the admissibility, of the evidence. *Lopez v. General Motors Corp.*, 224 Mich App 618, 632, n. 20 (1997); *People v. Stiller*, 242 Mich App 38, 55 (2000).

In other words, the court should not exclude evidence simply because the court disagrees with the conclusions of the expert or because the opinion fails to satisfy each and every criteria identified by *Daubert* or *Craig* or MCL 600.2955 as guides in evaluating the reliability of the testimony. If the underlying methodology used by the expert is fundamentally sound, reliable, or generally accepted, the testimony should be admitted.

Defendants will often make the objection that an expert's proffered opinion on some specific matter was not supported by reference to a published medical study precisely on point. But this is never a sufficient basis, in itself, for precluding the admissibility of the expert's opinion. Supportive medical literature is only one criteria to be considered in evaluating the foundation of an expert's opinion, not the exclusive criteria. Robins v. Garg, 276 Mich App 3451 (2007), Clerc v. Chippewa County War Memorial Hospital, 267 Mich App 597 (2005), affd, 477 Mich 1067 (2007), Heller v. Shaw Industries, Inc., 167 F3d 146 (CA3, 1997), Chapin v. A&L Parts, Inc., 274 Mich App 122 (2007). In Clerc the trial court had ruled an expert's testimony inadmissible solely on the basis that the expert had cited no medical literature in support of his conclusions relating to backward staging of cancer. In reversing, the Court of Appeals cautioned that the absence of medical or scientific studies specifically on point "should not necessarily operate as a complete bar" to the testimony because of ethical or reasoned constraints upon conducting such studies. It is sufficient-if-the basis for the expert's opinions are "generally accepted in the medical community as reliable" and the Court must also consider the experts' "individual knowledge and experience" as well as general knowledge in the scientific community as bearing upon its admissibility.

As was noted in the lead opinion of *Chapin, supra:*
The fact that two scientists value the available research differently and ascribe different significance to that research does not necessarily make either of their conclusions unreliable. Indeed, science is, at its heart, itself an ongoing search for truth, with new discoveries occurring daily, and with regular disagreements between even the most respected members of any given field. A *Daubert*-type hearing of this kind is not a judicial search for truth. The courts are unlikely to be capable of achieving a degree of scientific knowledge that scientists cannot. An evidentiary hearing under MRE 702 and MCL 600.2955 is merely a threshold inquiry to ensure that the trier of fact is *not* called on to rely in whole or in part of an expert opinion that is only masquerading as science. The courts are not in the business of resolving scientific disputes. The only proper role of a trial court at a Daubert hearing is to filter out expert evidence that is unreliable, not to admit only evidence that is unassailable. The inquiry is not into whether an expert's opinion is necessarily correct or universally accepted. The inquiry is into whether the opinion is rationally derived from a sound foundation.

See, Nelson v. American Sterilizer Co. (On Remand), 223 Mich App 485, 491-492; 566 NW2d 671 (1997).

It should be emphasized that the ruling of the trial court in Chapin merely found that the opinion testimony of Plaintiffs expert to be sufficiently reliable to be admissible into evidence, not conclusive as to the disputed issues of causation. Judge Davis' lead opinion noted:

> ... Both parties presented scientifically sound expert testimony tending to support their respective positions. Therefore, deciding this case at an evidentiary hearing, depriving the jury of the opportunity to fulfill its proper role as fact finder, would be inappropriate.

These cautionary words should be taken to heart, here, for in the present case Defendant's motion reveals no more than a disagreement between experts over the implications of relatively agreed upon scientific principles concerning the employment of narcotic agents to relieve pain in a clinical setting and a disputed issue of fact as to the cause of death in which experts have reached different conclusions applying the same scientifically reliable methodology.

B. Standard of Care

The relevant opinion regarding the Defendant Dr. Thamer's breach of the standard of care is probably best summarized at pages 65-66 of Dr. Genecin's deposition where he says that it was not the amount of Fentanyl that he criticized, but "the company it kept":
...So the decision to prescribe 75 micrograms patch was appropriate with respect to dosing when you look at the equivalent dosing for how much Dilaudid he was requiring, but the standard of care did not allow the doctor to double the dose of narcotics by adding the Duragesic without discontinuing the Dilaudid and dealing with breakthrough pain with a much milder and more short-acting drug during the period of time when the level was rapidly rising and he was at greatest risk for respiratory depression.

(Id, at 67)

This was not an opinion or conclusion pulled out of the ether but one informed by what Dr. Genecin, and every doctor dealing with pain medications, understood to be the risks associated with Fentanyl.

In this same passage Dr. Genecin referred to the "Dear Doctor" letter issued in 2005 by the manufacturer of this drug (**Exhibit 2**) which contains black box warnings of the risks of Fentanyl (Duragesic) causing hypoventilation (depressed breathing) and respiratory arrest, especially when used with other narcotic agents: (Emphasis has been added).

DURAGESIC contains a high concentration of a potent Schedule II opioid agonist, fentanyl. Schedule II opioid substances...have the highest potential for abuse and **associated risk of fatal overdose due to respiratory depression.**

Since the peak fentanyl levels occur between 24 and 72 hours of treatment, prescribers should be aware that serious or life threatening hypoventilation may occur, **even in opioid-tolerant patients, during the initial application period.**

Overstimulating the DURAGESIC dose when converting patients from another opioid medication can result in fatal overdose with the first dose. The mean elimination half-life of DURAGESIC is 17 hours...

Serious or life-threatening hypoventilation may occur at any time during the use of DURAGESIC especially during the initial 24-72 hours following initiation of therapy and following increases in dose.

The use of concomitant CNS active drugs requires special care and observation.

Respiratory depression is the chief hazard of opioid agonists, including fentanyl.... Respiratory depression is more likely to occur in **elderly** patients...or when given in conjunction with other drugs that depress respiration.

DURAGESIC should be used **with extreme caution** in patients with significant **chronic obstructive pulmonary disease...** and in patients having a substantially decreased respiratory reserve.

Because potent opioids can cause serious or life-threatening hypoventilation, DURAGESIC should be administered **with caution** to patients with **pre-existing medical conditions** predisposing them to hypoventilation. In such patients, normal analgesic doses of opioids may further decrease respiratory drive **to the point of respiratory failure.**

The concomitant use of DURAGESIC... with other central nervous system depressants, **including but not limited to other opioids, sedatives, hypnotics... may cause respiratory depression...** when such combined therapy is contemplated, **the dose of one or both agents should be significantly** reduced.

Ample medical literature and scientific studies have contributed to the attainment of the knowledge of the effects of Fentanyl that went into these warnings issued by the manufacturer of the Duragesic patch. Defendants can hardly deny that respiratory depression, leading to a possible respiratory arrest, is recognized as the chief hazard associated with this drug - an omnipresent hazard that is not mitigated by either the patient's level of opioid tolerance nor duration of administration. But it is a risk significantly increased, where, as in this case, the patient has COPD or other respiratory problems, (in which case it should be used only with "extreme caution"), or when used concomitantly with other opioid drugs, (Dilaudid is an opioid drug) or sedative, hypnotic drugs (Resperal is such a drug).

Given this scientifically established foundation for his testimony, the opinion of Dr. Genecin that it was a breach of the standard of care to prescribe a Fentanyl patch for Mr. Jones when he was already receiving another potent opioid drug every 4 hours for his pain and had a history of COPD, does not lie beyond the pale of reliable science or the published scientific literature. Adding Fentanyl at a dose 50% higher than he was given previously while still giving him the same dose of Dilaudid unnecessarily increased the risk of Mr. Jones suffering a respiratory arrest. This was especially true where these drugs were given concomitantly in circumstances where the patient's condition was not being continuously monitored. Dr. Thamer's actions needlessly increased the risk of respiratory depression without assuring that precautions were taken to prevent such depression from occurring when the Fentanyl rose to its peak levels during the night.

Defendant's chief criticism of Dr. Genecin's testimony are oblique from the main issue. Defendant criticizes Dr. Genecin's remarks that in his opinion Fentanyl should never be given with Dilaudid, asserting that nothing in the medical literature supports this extreme position. But here that testimony must be placed in context. As explained above, Dr. Genecin was criticizing the dual therapeutic use of Fentanyl and Dilaudid at-the same time. This is not a case, as already explained, where the Fentanyl patch was being used to manage the patient's pain long term and Dilaudid was only being used to address an episode of breakthrough pain. Admittedly, even then Dr. Genecin would prefer that some milder drug be used to control such pain. But the facts of this case concern using a Fentanyl patch continuously dispensing a narcotic together with continuous 4-hour doses of Dilaudid. *It was the ongoing persistent use of both opioids that Dr. Genecin criticizes.* Defendant, notably, has not presented to this court any medical literature that recommends treating a COPD patient with a combination of both Fentanyl and periodic repeated doses of IV Dilaudid. Given the information about this drug set out above, Defendant can make no valid objection to Dr. Genecin's opinion that the use of both medications for pain management, in the present case, was a breach of the standard of care.

In a similar vein, Defendant objects to Dr. Genecin's testimony that one of the reasons narcotic drugs are dangerous is that the tolerance a patient develops with respect to the analgesic effects of the drug does not equate with the body's tolerance to the depressive effects of the drug. Defendant claims that his experts have testified that a person who builds up a tolerance to the analgesic properties of a drug in fact also does develop a higher tolerance against respiratory depression. These experts can even cite to some medical literature to back up those claims. Plaintiff can point to the manufacturer's warning that "life threatening hypoventilation may occur at any time during the use of Duragesic" as some refutation of these assertions. However, these are disputed generalizations about the effect of these drugs divorced from the facts of this case. There are too many variables in this case for these generalizations to have much relevance here. Mr. Jones was not a statistical average person, but had a known history of COPD and sleep apnea. The medical records show that he had a tolerance to 50 mcg of Fentanyl combined with 1 mg of Dilaudid, but when he was transferred to Kindred the Dilaudid was doubled to 2 mg of Dilaudid and the Fentanyl increased by half to 75 mcg. Regardless of what medical studies may show to be a general correlation between analgesic and depressive tolerance to a steady administration of a narcotic to average patients, these cannot be extrapolated directly to the peculiar facts of this case. Ultimately the test of an individual patient's actual level of tolerance is determined by that patient's own reaction to the drug. And here decedent's lack of tolerance for the depressive effects of these drugs is demonstrated by the fact that he most probably suffered a respiratory arrest because of the excessive amount of opioids in his system.

C. Causation

In his deposition Plaintiffs expert, Dr. Genecin, testified that Mr. Jones' death was caused by hypoventilation (respiratory distress) that caused severe brain damage leading to death. (Id, 70). At pages 70 to 72 Dr. Genecin explains in detail the reasons that brought him to this conclusion. He explained that when a sudden death occurs in the hospital while a patient is not being closely observed, there are a variety of things to be considered as the cause of death. An embolism could be considered, but was unlikely in this instance because decedent was being anticoagulated and had a filter to curtail embolisms and the autopsy did not indicate an embolism. This patient also had a heart disease, but he had had a coronary bypass just a year before, and he had an implanted defibrillator which was not triggered by any ventricular abnormality associated with an arrest. So this cause should be ruled out. As to Defendant's pet theory that Mr. Jones might have simply had his heart stop - a PEA event - Dr. Genecin explained that the autopsy did not suggest an acute infarction and PEA would not be the kind of event associated with the type of heart problems Mr. Jones had. Therefore, by eliminating other possible causes of death, and looking at the full-clinical-picture,-what remained as the most likely cause of death, Dr. Genecin concluded, was hypoventilation brought on by a narcotic overdose. Of course, you know now that the pathologist, Dr. Spitz, who performed the autopsy agrees.

Defendant has presented to the Court the testimony of Defendant's experts reaching different conclusions as to the cause of death and argues that the court should accept their opinions as true and reject those of Dr. Genecin as not being scientifically reliable. But the fact is, these defense experts, in reaching their own conclusions, are simply applying the same well-recognized and accepted methodology employed by Plaintiffs expert, that of differential diagnosis. Differential diagnosis is a recognized scientific technique for determining the most plausible cause of an injury. See, e.g. Attorney General v. Beno, 422 Mich 293, 306, 311-312 (1985), Heller, supra Best v. Lowe's Home Centers, Inc., 563 F3d 171 (CA6 2009). Here experts on both sides used the same scientifically acceptable methodology to arrive at their conclusions. The fact that they arrived at different conclusions does not make either of them wrong or inadmissible. It is simply a matter that in arriving at these conclusions Plaintiffs expert placed more emphasis on the decedent's immediate clinical history of being medicated with highly potent opioids in making his differential diagnosis while Defendants' experts gave this clinical history little regard. But such differences in emphasis go to the weight and credibility of these witnesses, not to admissibility, and are matters for the jury to resolve.

As was noted in *Chapin, supra,* the fact that experts reach different conclusions from the same evidence does not mean that either one or the other conclusion is scientifically unreliable or inadmissible. The role of the court is limited to determining only if the opinions proffered rest on a sound foundation. Defendant here can hardly criticize Plaintiffs expert's causation opinions when it is clear that those opinions derive from the exact same methodology used by defense experts in reaching their own conclusions on causation. It is not the proper role of the court to resolve these disputed issues, but the role of the jury.

For these reasons, Plaintiff asks that Defendant's motion be denied.

Respectfully Submitted,

SOMMERS SCHWARTZ, P. C.

By

KENNETH T. WATKINS (P46321)

Attorneys for Plaintiff

2000 Town Center, Suite 900-

Southfield, MI 48075

(248) 355-0300

Dated: September 30, 2011

Footnotes

1 Consistently, Plaintiffs expert, Dr. Genecin, testified that in his view Henry Ford Hospital had also breached the standard of care by combining Fentanyl with a standing order for Dilaudid. However, Ronald Jones did not arrest while under that hospital's care.

2 At his deposition Dr. Genecin was not asked any questions pertaining to the effects of sepsis upon the narcotics given to Mr. Jones. Plaintiff has listed other causation experts who note that Mr. Jones' sepsis condition would also potentiate the effects of these drugs.

End of Document